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In The

Supreme Court of the United States

October Term, 1988

NANCY BETH CRUZAN, by her parents and co-guardians, LESTER L. and JOYCE CRUZAN,

Petitioners,

vs.

DIRECTOR OF MISSOURI DEPARTMENT OF HEALTH, and ADMINISTRATOR OF THE MISSOURI REHABILITATION CENTER AT MT. VERNON,

Respondents.

vs.

THAD C. McCANSE, Guardian ad litem,

Respondent.

On Petition For Writ Of Certiorari To The Missouri Supreme Court

BRIEF AMICUS CURIAE OF THE EVANGELICAL LUTHERAN CHURCH IN AMERICA IN SUPPORT OF PETITIONERS

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The Evangelical Lutheran Church in America is not requesting that this Court find a broad right to die. Rather this case involves the narrow right of an individual and her immediate family, free from unwarranted State intrusion, to decide the level of care appropriate for a loved one who can never regain any experience of human consciousness.

INTEREST OF AMICUS CURIAE:[1]

The Evangelical Lutheran Church in America [ELCA] has five and one-third million members in over eleven thousand congregations served by about seventeen thousand pastors. As part of its mission, it supports twenty-nine colleges, eight theological seminaries, 360 missionaries in 63 countries, 820 chaplains in the armed forces and 300 social service institutions, including hospitals, homes for older persons, and facilities for adults, youth and children with special needs.

The ELCA began its official existence January 1, 1988, as a merger of three predecessor church bodies, The Lutheran Church in America, the American Lutheran Church and The Association of Evangelical Lutheran Churches. These groups trace their history in this country to the Seventeenth Century.

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[1] The Evangelical Lutheran Church in America has received consent of the parties to the filing of this brief amicus curiae. Consent of Respondents was received from the Attorney General of Missouri and counsel for guardian ad litem, Thad C. McCanse, Esq., and of Petitioner from her attorney, Mr. William H. Colby, Esq.

This is the first brief the ELCA has filed in this Court. The filing of this brief is authorized by the Office of the Bishop and the Commission for Church and Society.

The guiding principles for positions of the Evangelical Lutheran Church in America on issues of social ethics are contained in Social Statements and Task Force Reports of its predecessor church bodies. The ELCA takes the position it does in this brief because of two such documents: a 1977 paper issued by the American Lutheran Church's Task Force on Ethical Issue in Human Medicine, [reprinted in Appendix A], and The Lutheran Church in America's Social Statement entitled Death and Dying that was adopted by the Eleventh Biennial Convention of that body in 1982, [reprinted in Appendix B].

Both the prior church bodies that comprise the ELCA recognized in their documents that new technologies in medicine can "keep people alive biologically until life becomes an intolerable burden." [App. p. A1] Medical interventions "do not always cure, but sometimes only prolong the dying process." [App. p. B1] With respect to chronically ill persons, the LCA statement took a strong position in favor of treatment except "in case of extreme and overwhelming suffering from which death would be a merciful release, or in cases in which the patient has irretrievably lost consciousness." [App. p. B9]

Similarly, the ALC Task Force paper affirms the use of life support systems whenever they serve "to improve the quality of personal and biological life." [App. p. A4] However, "wherever personality and personhood are

permanently lost, artificial supportive measures often are seen as unfair to the dignity of the person . . . " [App. p. A5]

These conclusions were reached because of the ELCA's theological understanding of life and death, all of which is in God.

God's gift of dominion over the earth calls us "in our lifetime . . . to be good stewards of all that we are and have." [App. p. A6] "Both living and dying are part of the dynamic processes of the created order, which Biblical faith affirms as being good." [App. p. B2] Both should occur within a caring community that mandates respect for each person. [App. p. B4]

Medical decisionmaking is a personal matter and "we affirm the human right of individuality which allows us to die our own death within the limits of legal, social, and spiritual factors." [App. p. A3] At the same time, we acknowledge our interrelated and interdependent nature, and seek to provide an individual facing death with the love and care of family and close friends. [App. p. B5]

Above all, "Christian faith teaches us the duty of preserving health, but does not hold life to be an absolute value . . . Our hope is the hope of the resurrection." As "Christ affirmed his death as an event that glorified God so can we affirm our own death." [App. p. A6] "As life draws to an end, with no hope for health restoration, permitting death is often the most heroic, caring and charitable rendering of stewardship." [App. p. A5]

LAW AND ARGUMENT

This is not a case about a person's right to die. Rather, an individual and her immediate family seek a narrow constitutional protection from unwarranted intrusion by the state in private family decisions made within the sanctuary of a home environment.

The Supreme Court of Missouri appeared to acknowledge such a constitutional right in this case, but found that the state's expression of a strong policy favoring life "outweighs any rights invoked on Nancy's behalf to terminate treatment." [Petitioner's App. p. 43] Relying on *Bowers v. Hardwick*, 478 U.S. 186 (1986), the Missouri court had "grave doubts as to the applicability of privacy rights to decisions to terminate the provision of food and water to an incompetent patient." [Petitioner's App. p. 25]

The court's reliance on *Bowers* is misplaced. In *Bowers*, this Court held that the federal right to privacy does not protect homosexual activity, finding "[n]o connection between family, marriage or procreation on the one hand and homosexual activity on the other . . . " [p. 191]. This court emphasized in *Bowers*, however, that traditional rights not expressly set out in the text of the constitution are nonetheless protected as fundamental privacy and liberty rights under the liberty provision of the Fourteenth Amendment. These fundamental rights fall into several categories: those protecting family relationships, *Meyer v. Nebraska*, 262 U.S. 390 (1923); *Pierce v. Society of Sisters*, 268 U.S. 510 (1925), *Moore v. City of East Cleveland*, 431 U.S. 494 (1977)(Plurality opinion); the privacy of the home, *Poe v. Ullman*, 367 U.S. 497, 542 (1961)(Harlan J. dissenting), *Griswold v. Connecticut*, 381

U.S. 479 (1965), and those providing protection for certain kinds of intimate decisionmaking within these spheres, *Loving v. Virginia*, 388 U.S. 1 (1967)(marriage); *Griswold v. Connecticut, supra* (contraception) and *Roe v. Wade*, 410 U.S. 113 (1973)(abortion).

Mr. Justice Brandeis explained the basis for these rights in *Olmstead v. United States*, 277 U.S. 438, 478 (1928)(dissenting opinion): "The makers of our Constitution . . . recognized the significance of man's spiritual nature, of his feelings and of his intellect. They knew that only a part of the pain, pleasure and satisfactions of life are to be found in material things. . . . They conferred, as against the government, the right to be let alone . . ."

The right to be let alone is especially important as it protects the privacy of the family and the home. "The home derives its pre-eminence as the seat of family life." *Poe v. Ullman, supra* at 551 (J. Harlan, dissenting). It is here that parents are free to teach their children; *Pierce* and *Meyer, supra*, to share sexual intimacy; *Griswold v. Connecticut, supra*, to "pass down many of our most cherished values, moral and cultural." *Moore, supra* at 504. Indeed, in a somewhat different context, both the Third and Fourth amendments recognize this right against arbitrary intrusion by the police and military power of the state.

If this protected "private realm of family life" includes sexual intimacy, procreation, education and family relationships, it "would indeed be straining at a gnat and swallowing a camel", *Poe, supra* at 552, to recognize this aspect of family privacy without understanding and

upholding the historical and traditional place of dying in the same context.

It has long been the case that, in death, persons have expressed their most profound beliefs and private intimacies. Not many years ago, most deaths occurred at home. There, "[s]urrounded by family and friends, dying people were invited to repent of their sins, bless the children present, ask forgiveness, bid farewell and make recommendations." [App. p. A1] Death occurred as a natural and private experience. Today, "people often experience death in the sterile environment of hospital or nursing home," [App. p. A2] often connected to "new technologies [that] do not always cure but sometimes only prolong the dying process, at times with great suffering." [App. p. B1]

The relationship between the home and family privacy is especially important in Nancy Cruzan's case. Here, as in *Griswold*, "we have not an intrusion into the home so much as in the life which characteristically has its place in the home." *Poe, supra* at 551. "Especially in times of adversity, such as the death of a spouse or economic need, the broader family has tended to come together for mutual sustenance and to maintain or rebuild a secure home life." *Moore, supra* at 505. As Mr. Justice Brandeis warned in *Olmstead, supra* at 479, the state's invasion into the privacy of the home should be most suspect in a case like this one, where "the Government's purposes are beneficent . . . The greatest dangers to liberty lurk in insidious encroachment by men of zeal, well-meaning but without understanding."

Nancy Cruzan's loving family, following careful and agonizing deliberation, has decided to discontinue Nancy's artificial hydration and nutrition. Their decision was based on a lifetime of knowing Nancy and what she would want, her prior expressed wishes and careful family deliberation and prayer. This decision was affirmed following an extensive trial proceeding, and concurred in by a Guardian ad litem appointed to protect Nancy's interests.

The Supreme Court of Missouri has wrested this decision from Nancy Cruzan and her family, placing it instead in the hands of the state. Although a state has a legitimate interest in assuring a careful deliberation and fair decision on behalf of an incompetent person, the Missouri court has decided that artificial fluids and nutrition, once undertaken for a restorative purpose, must be continued forever, irrespective of the lack of success or benefit to a patient. Once a patient's body is given to medical science, it remains a prisoner there, presumably until some force beyond the power of medical technology intervenes.

The Missouri Court's decision invades the privacies of family and home as certainly as the decision of Connecticut invaded the privacy of the marital bedroom in *Griswold*. It is as if the agents of the state of Missouri have been quartered in Nancy's home, ostensibly to preserve her life, but in actuality demanding up to thirty years of continued enslavement to the pain of medical intervention that no longer serves a hopeful purpose. Her doctors agree that Nancy will not improve; her parents, the repository of her prior existence, simply ask to let her depart in peace.

Only this Court can recognize the fundamental constitutional value of the Cruzans' request. Without recognition of this family's prerogative to decide, many others like Nancy Cruzan will fall victim to medical technology which has won a battle but lost the war, prolonging misery without hope of improving and restoring life.

In considering whether to grant certiorari, the ELCA respectfully requests that this Court consider that a person of faith who makes a decision to discontinue artificial hydration or nutrition should not be forbidden from doing so. We believe that for us, such a decision requires prayerful consideration of the gift of life from God, respect for every person including their treatment decisions and hope in the resurrection over death. Our freedom to believe and to act on that belief in the privacy of our families is inextricably bound to the Cruzan family's struggle to do the same.

In dying, as in conceiving and birthing, humans share their greatest intimacies and most profound beliefs. To many if not most, these beliefs include the comfort of a loving God who creates us and our world and entrusts life, nurture and growth to our guardianship. Part of this creation includes the abundant blessings of medicine, which offer us freedom to live longer and fuller lives than ever before in human history. Our use of medical intervention, like our use of the earth, must be for the service of humankind. Though we as Christians fight for life and treasure it, when life in community is no longer possible, we trust in the assurance of a new life when our earthly bodies fail. At that time, we wish to be free to repeat the words of Simeon, upon seeing the infant Jesus: "Lord, now lettest thou thy servant depart in peace according to

thy word; for mine eyes have seen thy salvation which thou hast prepared in the presence of all peoples." [Luke 2:29-31][2]

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[2] First Amendment religion clause claims have not been made in the case. However, for persons of faith, decisions concerning care for a loved one will inescapably involve religious belief. Similarly, *Meyer* and *Pierce supra*, involved claims of Fourteenth Amendment protection against the power of the state where religious belief primarily motivated the private action.

CONCLUSION

If this Court grants certiorari, it need only decide a narrow question: whether a state may remove from a family and guardian all decisionmaking power concerning a particular medical intervention where the state's own hearing has shown that the family and guardian ad litem are all acting in the best interests of the permanently unconscious person.

For the reasons set forth herein, your amicus curiae requests that the petition for a writ of certiorari be granted.

Respectfully submitted,

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May 2, 1989

APPENDIX A

DEATH AND DYING

An analysis offered by Task Force on Ethical Issues in Human Medicine, Office of Research and Analysis, The American Lutheran Church – July 1977.

A. Facing Death

1. Death is a natural event in the course of human life. However, we experience a paradox about death. We have the technological means to make dying easier, yet we may have arrived at a time in life when we have overlooked the meaning of persons. Our society has the technology to keep people alive biologically until life becomes an intolerable burden. Therefore, moral problems exist with respect to death and dying in a technological society.

2. Earlier societies respected death through ritual and customs that gave meaning to the personal aspects of death. Most often death occurred at home. Surrounded by family and friends, dying people were invited to repent of their sins, to bless the children present, ask forgiveness, bid farewell, and make recommendations. Death occurred as a natural experience, expected and understood. Yet death, then as now, remains the most stressful of all human events.

3. Death seems to have lost its public, social, and spiritual character in a new style of dying. What has become important is that one dies in a manner that can be accepted and tolerated by a surviving family, friends, medical personnel, and the church. Today people often

experience death in the sterile environment of hospital or nursing home. One may die alone, surrounded by people who often abandon the dying person for multiple reasons. Often the dying person plays the role of the one who does not know, or want to know, that death is imminent. "Shielded," isolated, and sedated, the dying person experiences death as a tragic comedy, supported by a cast of actors and actresses playing deceptive roles in a conspiracy of silence.

B. Affirming Life – and Death

4. We believe in the sanctity of life. This means that life is to be celebrated in the spirit of creative Christian living since life has worth, meaning, and purpose both in its living and in its dying. Christ's work of redeeming and transforming people begins in baptism, yet it is directly related to death. For baptism points in two ways – to creation and to eternity. The one who is baptized dies with Christ and is raised with him. Baptism binds together the believer and Christ within one body, the church. Our baptism is into the death and resurrection of Jesus and is our own journey through death to life, death of the sinful self and the birth of the new self with all that it implies for the meaning of human life. In the Lord's Supper we experience repeatedly the real presence of Christ in a reaffirmation of life, dignity, forgiveness, and promise. Faith in Christ affirms the fact that his death and resurrection are meant for all persons on this earth.

5. We affirm that death is a personal matter. Strong ambivalent feelings toward death make for our difficulty in communicating with each other about this event. We

are both fearful and yet curious about death. Our own personal feelings, personality, hopes, and experience of faith are major factors in our personal fear and denial of our acceptance of death. Coping with our own death and the death of others is further colored by society's attitude toward life. Contemporary society, with its emphasis on youth, affluence, and technology is preoccupied with fun morality. This confuses the wisdom of the ages, affecting values of life as well as of death.

6. We affirm the human right of individuality which allows us to die our own death within the limits of legal, social, and spiritual factors. Death is a personal experience. Our relationship with the dying is a relationship with a person. Persons have the right to die peacefully – respected, cared for, loved, and inspired with hope. Those who care for the dying, namely family, physicians, nurses, and the clergy, merit our high regard for this serious task.

C. Defining Death

7. We seem to need a definition as to when death occurs. Medical and technological advances in supportive therapy and resuscitation measures have given hope to many, but also clouded the issue of when death occurs. No exact biological, legal, or theological determinants are clear. Medical and legal bodies have been seeking new guidelines for consideration on this issue. One resolution calls for a legal definition of death as the "irreversible, total cessation of brain function." Another definition discusses the irreversible cessation of the functioning of all vital organ systems.

8. We affirm that definitions of death consist of more than biological facts. They must also consider the personal and the spiritual dimensions of life. Since the dimensions of biology and personhood are present in every instance of life and death, both deserve equal consideration in any serious attempt to render definition.

D. Sustaining Life

9. When death is judged to be certain and imminent, we affirm that grave injustice to the respect and memory of persons is rendered if extraordinary technology is applied. Our highest concern is for the total person rather than technological curiosity and mechanical performance. We are confronted with values of human and personal life in the face of every death.

10. Wherever life support systems can be used to improve the quality of personal and biological life, we heartily affirm their use. We respect medical advances as marvelous instruments for serving others. Social justice, charity, potential health, and the respect of personhood usually determine the reasons for continuing artificial support systems. We affirm the person's right in these situations to reasonable health care for maintaining and sustaining personal life, if one so chooses. When people consciously will life, experiencing existence with meaning and purpose, suffering is not in vain. Hope, comfort, and love should be shared with those suffering.

11. Christianity has long taught that suffering can have meaning. Through it God can work his grace for the one who suffers and for others. Redemptive suffering is meaningful pain. This is markedly different from the

dehumanizing and mindless suffering of the artifically-maintained terminally ill.

E. Allowing Death

12. We affirm that in many instances heroic and extraordinary means used to prolong suffering of both the dying person and the loved ones is unkind. Wherever personality and personhood are permanently lost, artificial supportive measures often are seen as unfair to the dignity of the person and an extreme cost that is burdensome to the family. Families in these cases need not feel a burden of guilt for refusal to try unusual, heroic, and extraordinary life support. Where physicians have determined the irreversible phase of a terminal illness, we affirm that the person, young or old, has a right to a peaceful death. As life draws to an end, with no hope for health restoration, permitting death is often the most heroic, caring, and charitable rendering of stewardship.

13. We affirm that every situation, in the context of dying persons, deserves consideration and decision on its own merit. We affirm that life is to be respected. Respect for the patient requires acceptance by others of that person's desires for life and death. Wise counsel by physicians, the clergy, and members of the health care team should be made available to every family and person facing the crisis of death. Wherever possible, the dying person has a right to be informed of the nature of the illness and the likelihood of imminent death. One should be so informed in love.

14. We affirm that direct intervention to aid the irremediably deteriorating and hopelessly ill person to a

swifter death is wrong. While direct intervention in many cases may appear "humane," deliberate injection of drugs or other means of terminating life are acts of intentional homicide. This deliberate act is far removed from decisions which allow people to die – like shutting off a life-supporting machine or even withholding medication. Permission for the normal process of death is an act of omission in the spirit of kindness and love within limits of Christian charity and legal concerns. Direct intervention to cause death, known as direct euthanasia, can not be permitted. We affirm there is a distinct moral difference between killing and allowing to die.

F. Living under the Gospel

15. Christian faith teaches us the duty of preserving health, but it does not hold life to be the absolute value. While we are often helpless to contend with death, we are not helpless in the acceptance of death. We should accept it with all of its devastation to our earthly hopes and values and, in doing, affirm the ultimate victory we gain in Christ. Our hope is the hope of the resurrection. As Christ affirmed his own death, so can we our death. As he affirmed his death as an event that glorified God, so can we affirm our death. Christ's victory over death makes our death the climax of life, and end to which we have been continually moving.

16. Christians live under the Gospel. In our lifetime, we are called to be good stewards of all that we are and have. Stewardship of life, even our death, is filled with critical moments of tension, joy, and anguish. We affirm the fact of our faith that death, too, has meaning, as life

has meaning. We affirm that to the Christian, dying can be the summit from which one can view the totality of one's life, an accounting of personal stewardship. In grace, we can boldly claim the promises of God about life and death. The promises are everlasting.

APPENDIX B

SOCIAL STATEMENTS

THE LUTHERAN CHURCH IN AMERICA

DEATH AND DYING

Adopted by the Eleventh Biennial Convention,
Louisville, Kentucky
September 3-10, 1982

Today it is commonplace to speak of the triumphs of modern medicine – achievements such as open heart surgery and organ transplants, dialysis machines that substitute for the kidneys, pacemakers that regulate the beating of the heart, and vaccines that have made once-dreaded diseases almost forgotten words. Each of these discoveries has saved countless lives and relieved much suffering. None of this, however, has changed the fact that death still occurs. The new technologies do not always cure but sometimes only prolong the dying process, at times with great suffering. The irony of modern medicine is that with the new technologies that vastly expand the range of what it is possible to do has also come the anguish of deciding when it is appropriate to use these capabilities.

Nowhere are these ethical dilemmas more pressing than with respect to death and dying. A terminal cancer patient who is experiencing great pain suffers cardiac arrest; should the patient be resuscitated? A newborn infant with massive and multiple birth defects is unlikely to survive without surgical intervention; is such intervention appropriate? A family member with a life-threatening illness refuses to undergo treatment; should

treatment be administered in violation of his or her expressed wishes? In these and countless similar situations, we confront not only the grief and anguish always associated with death and dying, but also new and difficult moral decisions that call for prayerful reflection and the support of a caring community.

THEOLOGICAL PERSPECTIVES ON DEATH AND DYING

Perspectives on death and dying within the Christian tradition, both in its biblical origins and in its subsequent development, reflect several contrasting and complementary themes:

Death as Natural. Death is frequently viewed as a natural part of the life cycle. Like all other creatures, human beings have a limited life span. "The years of our life," the psalmist observed, "are threescore and ten, or even by reason of strength fourscore" (Psalm 90:10) The fact that our span of life is limited serves to remind us that we are finite. We are created by God; we are not God. Both living and dying are part of the dynamic processes of the created order, which biblical faith affirms as being good. The story of Abraham's death reflects this view: "Abraham breathed his last and died in a good old age, an old man and full of years, and was gathered to his people" (Genesis 25:8).

Death as Tragic: Death may also be experienced as an unwelcome event that involves a tragic dimension. Sometimes this is because death seems untimely, as in the case of a dying child, a youth, or an adult in the prime of life. Or its unwelcomeness may be due simply to the desire to

continue living rather than depart life, a desire that in its own way gives eloquent testimony to the goodness of the life that God has created. Sometimes the reluctance to die arises from dread of the suffering which may accompany the dying process. Thus it is in keeping with a wide range of human experience that the psalmist prays for deliverance form mortal illness: "Turn, O Lord, save my life; deliver me for the sake of they steadfast love" (Psalm 6:4).

Death as Friend. When dying involves prolonged suffering, death can be experienced as a deliverance, and in this sense as a friend. This does not imply that one should deliberately end life to avoid suffering, for the Christian witness is that meaning and hope are possible even in deepest adversity. It does imply that death, when it brings relief from suffering, can be understood and accepted as merciful.

Death as Enemy. Even though death must be viewed as part of the created order and can sometimes be a friend, the sinfulness of the human condition makes death an enemy. As the apostle Paul puts it, "The sting of death is sin" (I Corinthians 15:56). The alienation and estrangement that are pervasive in our lives make us unready to face death, an anxiety that may be heightened by fear of what lies beyond the grave.

Victory over Death. The New Testament message of Christ's victory over death speaks directly to this alienation and anxiety. Through Baptism, the believer is buried with him "into death, so that as Christ was raised from the dead by the glory of the Father, we too might walk in newness of life" (Romans 6:4). The new life of faith

enables the Christian to face death with courage and with the assurance of forgiveness. The promise of the resurrection of the body and eternal life provides comfort and reassurance that death is not the end.

Whether death is viewed as natural or as tragic, as a friend or as an enemy, all who experience death-and-dying situations can be certain of God's love. Thus the apostle Paul asserts, "For I am sure that neither death, nor life, nor angels, nor principalities, nor things present, nor things to come, nor powers, nor height, nor depth, nor anything else in all creation, will be able to separate us from the love of God in Christ Jesus our Lord" (Romans 8:38-39).

ETHICAL DECISION-MAKING

Careful and prayerful reflection in the immediacy of the situation is an essential ingredient in a responsible decision-making process. At the same time, Scripture, tradition, and the shared wisdom of Christian people provide important resources for making these decisions.

While the exact nature of death-and-dying situations can never be anticipated fully, it is possible to identify interpretive principles that are useful in shaping our response. These include the following:

1. Life is a gift of God, to be received with thanksgiving.
2. The integrity of the life processes which God has created should be respected; both birth and death are part of these life processes.
3. Both living and dying should occur within a caring community.

4. A Christian perspective mandates respect for each person; such respect includes giving due recognition to each person's carefully considered preferences regarding treatment decisions.
5. Truthfulness and faithfulness in our relations with others are essential to the texture of human life.
6. Hope and meaning in life are possible even in times of suffering and adversity – a truth powerfully proclaimed in the resurrection faith of the church.

The decision-making process involves not only the question of what principles should be used in responding to death-and-dying situations but also the questions of who should make such decisions. If the person is capable of actively participating in the decision-making process, respect for that person mandates that he or she be recognized as the prime decision-maker. At the same time, to relegate such decisions solely to the individual facing death is to deprive that person of love and care. Therefore, it is appropriate that the physician, family members, close friends, the pastor, and other members of the health care team play a supportive role.

If the person in question is not capable of active participation, the situation is somewhat more complex. In some cases, the person's clearly stated preferences, made before he or she lost the capacity to participate, are on record; respect for that person requires that these preferences be given recognition. In other cases, no preferences are on record because the person never gave expression the his or her preferences while still able to do so, and is now too weakened to respond. If the situation involves a child under the age of majority, who is therefore legally

incompetent, or a person who is mentally impaired and hence unable to participate fully in the decision-making process, a shared decision-making process is preferable. Collective wisdom is likely to result in better decisions, and no one should be left to bear alone the full burden of deciding. Participants in this decision-making process may include family members, the physician and other health care professionals, the pastor, and others close to the person. If it is not possible for those immediately involved to reach a consensus, a hospital ethics committee, if one exists, can be an important resource. Appeal to the courts should be avoided unless so doing is the only way to protect individual rights or to resolve the controversy.

WITHDRAWING AND WITHHOLDING TREATMENT

Among the most difficult decisions which confront family members and others in death-and-dying situations are those that involve withdrawing or withholding medical treatment. Opinions differ as to whether there is a significant ethical difference between withdrawing a treatment (e.g., a respirator) that has already been initiated, and simply deciding not to administer it in the first place. Both, essentially, are decisions not to treat.

The situations in which these treatment decisions arise vary widely. At least three different types of situations can be identified, each of which demands a different response:

A. The Irreversibly Dying Person

The first type of situation involves persons whose disease is progressive and for whom no effective therapy is available. As the final stages of the dying process occur, there comes a time to recognize the reality of what is happening by refraining from attempts to resuscitate the person and by discontinuing the use of artificial life support systems. To try desperately to maintain the vital signs of an irreversibly dying person for whom death is imminent is inconsistent with a Christian ethic that mandates respect for dying, as well as for living.

This does not, however, in any way preclude supportive care intended to maintain comfort and otherwise respond to the needs of the dying person. Indeed, quite the opposite is the case; when no cure is available, the responsibility to extend loving care not only continues but assumes even greater importance. This includes not only controlling physical pain, but also responding to the fear, guilt, and anger, the sense of isolation, the blocked communications, and the family stress that are often experienced by the dying.

B. Burdensome Treatments

In some cases there are forms of therapy which offer prospects for sustaining life but which themselves involve considerable discomfort, thereby necessitating a choice between quantity of life and quality of life for the patient. Examples of this type of situation include persons with widespread malignancy who are experiencing extensive side effects from chemotherapy and terminally ill children whose lives can be sustained for a greater

period of time if they are hospitalized, but who will be separated from their familiar home environment. In such cases, the issue is whether it is preferable to have a greater number of days that are overshadowed by the rigors of therapy or a lesser number of days that are more peaceful, i.e., whether quantity of life or quality of life should be accorded priority.

Factors to be considered in making these decisions include the following:

1. The probability that a particular form of medical treatment will help sustain the life of the patient.
2. The length of time that the life of the patient is likely to be sustained.
3. The anticipated risks and side effects of the treatment
4. Other forms of treatment available, if any, and their relative advantages and disadvantages
5. The patient's adjustment to hospitalization or to the treatment
6. The extent to which the treatment will interfere with the person's most cherished activities.
7. Available support systems at home or in alternative institutional settings

Second opinions and consultations are often useful in clarifying and assessing these factors.

C. Chronically Ill Individuals

The foregoing should not be taken to imply that chronically ill persons should be allowed to die because their lives are judged to be not worth living or because they

are viewed as burdensome or useless to society. Whether the person in question is a newborn infant with serious birth defects or an aged person whose capacities have begun to wane, the Christian response in such cases must be a strong presumption in favor of treatment. Exceptions might arise in cases of extreme and overwhelming suffering from which death would be a merciful release, or in cases in which the patient has irretrievably lost consciousness.

Just as abandoning the chronically ill to die is inconsistent with Christian conscience, so also is abandoning the family members who, along with the patient, must bear the psychological, social, and economic costs of chronic illness. Responding to these needs involves the stewardship of time (e.g., offering to share in the responsibility of caring for a chronically ill person) as well as seeking to make adequate financial resources and supportive services available, whether by public or private means.

Finally, to assert that all lives are worth saving does not eliminate the necessity of establishing priorities when available medical resources are inadequate to treat all who are in need. In these tragic situations, it is inevitable that the priorities that are established, regardless of what they might be, will result in reduced levels of treatment for some, perhaps even to the point that death occurs earlier than would be the case if adequate resources were available.

REFUSING TREATMENT

If the patient has the prime decision-making role, the question then becomes one of refusing treatment for oneself, rather than withdrawing or withholding treatment from another. Since our responsibilities for stewardship of our own lives do not differ significantly from our responsibilities for the lives of others, the general guidelines outlined above are pertinent here also. Thus, for example, one may in good conscience refuse burdensome treatments in some situations.

A further question, however, also arises: Should persons be allowed to refuse treatment in situations in which such refusal is not supported by these guidelines? Or should they be treated in violation of their wishes? Here the principle of respect for individual self-determination comes into play. To treat a patient in violation of his or her deeply held, carefully considered, and clearly expressed preferences is to do violence to that person just as surely as would physically assaulting that person or deliberately destroying his or her property. This is as true in the case of an incompetent patient who has made his or her preferences known while still competent as it is in the case of a competent patient who can actively participate in the decision-making process.

At the same time, it must be emphasized that pain and other factors often distort the decision-making process, resulting in expressions of preference that may not represent a person's true wishes. In such cases, it may be appropriate to administer treatment (by authority of court order, if necessary) if so doing would sustain the life of the patient.

In all cases – including those situations in which a person's considered judgments are unmistakably clear – there is a continuing responsibility to care for and to extend the warmth of human community to that individual. A decision to allow refusal of medical treatment must never become an excuse for abandoning that person.

USE OF PAIN-KILLING DRUGS

In certain instances, some drugs administered in order to control pain experienced by terminally ill patients also have the effect of hastening the dying process, thus securing a better quality of life at the expense of quantity of life. As with burdensome forms of therapy, it is appropriate to ask whether there are alternative courses of action that do not pose this conflict – i.e., whether there are available means of controlling pain that would not hasten death. If there are not, the choice between quality and quantity of life cannot be avoided. In cases of great suffering, administering pain-killing drugs is justifiable even if this hastens the dying process. At the same time, adjustments in administering such drugs should be made so as not to deprive the patient of consciousness prematurely. In all cases, recognition should be given to patient preferences, when they are known.

ACTIVE EUTHANASIA

Deliberately administering a lethal drug in order to kill the patient, or otherwise taking steps to cause death, is quite a different matter. This is frequently called "active euthanasia" or "mercy killing" (as contrasted with the cases discussed above, which involve withholding or

withdrawing medical treatment, thereby allowing death to occur from a disease or injury).

Some might maintain that active euthanasia can represent an appropriate course of action if motivated by the desire to end suffering. Christian stewardship of life, however, mandates treasuring and preserving the life which God has given, be it our own life or the life of some other person. This view is supported by the affirmation that meaning and hope are possible in all of life's situations, even those involving great suffering. To depart from this view by performing active euthanasia, thereby deliberately destroying life created in the image of God, is contrary to Christian conscience.

Whatever the circumstances, it must be remembered that the Christian commitment to caring community mandates reaching out to those in distress and sharing hope and meaning in life which might elicit a renewed commitment to living.

CARING FOR THE LIVING AND FOR THE DYING

Health care includes not only attempting to cure disease and repair injury, but also caring for and relating to the patient as a person. As noted above, in the case of a terminally ill person for whom no cure is available, the responsibility to care not only continues, but assumes even greater importance, so that life may be lived to the fullest until death occurs.

Moreover, the responsibility to care includes extending care to the family and to all those who are involved in such situations. Hospice programs (which provide a wide

range of supportive services for patients and their families) and other supportive care programs represent useful and constructive ways of assisting the patient and family members in relating to the human dimensions of death and dying and subsequent bereavement. Such support for family members is needed in cases of sudden death, as well as prolonged terminal illness.

Health care professionals as well as family members have a responsibility to be truthful in relations with patients. Information must be shared so that the person can understand the disease and the options for treatment. Being informed of terminal illness is also essential so that one can prepare for death.

In death-and-dying situations, the Church's ministry of Word and Sacrament through its members and ordained ministers is of great significance. Remembrance of Baptism renews the Christian's sense of unity with Christ and the Church, and the Sacrament of Holy Communion serves as a reassurance of Christ's living presence and offers hope for the life to come. Simply to be with those for whom death is approaching – to pray with and for them, to listen and to respond, to comfort and to console – is also an essential ministry.

A commitment to caring community must also give recognition to the humanity of health care professionals, who are frequently asked to bear tremendous burdens. They, too, have a need for grief therapy sessions and other supportive programs, which in turn will enable them to minister more effectively and compassionately to patients and their families and friends.

A particular responsibility of each individual is making treatment preferences known, after careful consideration, so as to facilitate the decision-making process and relieve the burden on others. Living wills (signed and witnessed statements completed while a person is still in sound mind indicating treatment preferences) represent one way of doing this. Other areas of broader responsibility for patients and family members include considering the possibility of organ donation as a means of sharing life with others, authorizing an autopsy, and the donation of the body for scientific purposes.

FORGIVENESS AND THANKSGIVING

There is much that we do not know. We do not know when a debilitating disease may strike, what course that disease might take, and when death will occur. And there is much that we do not understand. Sometimes the death of a child or the large measure of suffering that may accompany the dying process seems to make no sense at all. Our finitude not only involves the fact that our life spans are limited; it is also reflected in the limitations of what we know and can understand.

Moreover, in responding to the dilemmas that are thrust upon us in death-and-dying situations, we sometimes make the wrong decision, or at least are uncertain as to whether we have made the right one. And we are often woefully inadequate in extending compassion and understanding to our fellow human beings. Even in the best of circumstances, our sins and shortcomings are manifold.

But this we know: God is merciful and forgiving. Thus, by grace, we can both experience forgiveness and forgive others, as God forgives us.

We also know that God may be closest to us in times of adversity, for then the pretensions that alienate us and the diversions which preoccupy us are stripped away. It is then that we learn to rejoice again in the marvelous gift of life, and the privilege of sharing this life with family and friends and all those we have known and loved. Thus even at the moment of death we can proclaim with the psalmist:

> O give thanks to the Lord, for he is good; for his steadfast love endures for ever! (Psalm 107:1)

IMPLEMENTING RESOLUTION

The Lutheran Church in America recommends to its congregations and their members, synods, agencies, and institutions, the following as appropriate ways of implementing the principles set forth in the statement "Death and Dying."

I. Congregations

A. Provide an educational program that includes sessions on death and dying, so as to encourage members to reflect about these issues within a Christian context.

B. Sponsor training sessions to help members learn how to minister to the chronically ill and to those in death-and-dying situations, and to members of their families.

C. Encourage the development of mutual support groups within the congregation.

D. Join with other congregations and community groups to establish and maintain supportive care programs, including hospice care.

II. Churchwide Agencies, Synods

A. Prepare study material on death and dying to be used in educational programs.

B. Provide continuing educational opportunities and supportive services for clergy and laity to help them relate effectively to death and dying.

C. Encourage the development of hospice programs and other supportive care programs designed to respond to the human dimensions of death and dying.

D. Advocate with federal, provincial/state and local governments legislation and administrative regulations that advance the best interests of persons with respect to dying and death.

E. Advocate and support public and private measures designed to relieve the economic burden of terminal illness and to promote the just distribution of medical resources.

III. Church-Related Health Care Institutions and Social Service Agencies

A. Review and discuss institutional policies in terms of the guidelines outlined in the social statement.

B. Introduce and maintain programs designed to help health care professionals deal with death and dying.

C. Introduce and maintain programs designed to help patients and members of their families relate to death and dying.

IV. Educational Institutions (Seminaries and Church-Related Colleges)

A. Design college courses and programs on issues related to death and dying.

B. Provide seminary courses and programs to train future pastors and lay professionals for their ministry to the dying and to members of their families.

C. Cooperate with the synods in offering continuing education for clergy and laity in this area of concern.

V. Individuals

A. Prayerfully examine the ethical questions related to death and dying and make treatment preferences known to family members and to others as appropriate (e.g., by completing a living will).

B. Share time and other resources with those whose lives are affected by chronic illness or by death and dying.

C. Consider the possibility of organ donation as a means of sharing life with others.

ADDENDUM TO SOCIAL STATEMENT ON DEATH AND DYING

Adopted by the Eleventh Bienneal Convention
of the Lutheran Church in America
Louisville, Kentucky
September 3-10, 1982

The Twelfth Biennial Convention of the Lutheran Church in America (Toronto 1984) adopted a memorial from the Virginia Synod directing "that all references in the Death and Dying Statement that call death '(a) friend' be changed to 'merciful'."